		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018275

Facility Name: Alpine Fireside Health Center

Address: 3650 N. Alpine Road (Number) Rockford (City) 61114 (Zip Code)

County: Winnebago

Telephone Number: (815) 877-7408 **Fax #** (815) 877-9818

IDPA ID Number: 362753251001

Date of Initial License for Current Owners: 1973

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 207-2264
Altschuler, Melvoin & Glasser LLP
30 South Wacker Drive
Chicago, IL 60606-7494
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/1999 to 9/30/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, 30 South Wacker Drive, Chicago, Il 60606-7494
(Telephone) (312) 207-2264 Fax # (312) 207-2958

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	23,058	3
4		Intermediate/DD			4
5	64	Sheltered Care (SC)	64	23,424	5
6		ICF/DD 16 or Less			6
7	127	TOTALS	127	46,482	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	10,255	9,642		19,897	10
11	ICF/DD					11
12	SC		7,092		7,092	12
13	DD 16 OR LESS					13
14	TOTALS	10,255	16,734		26,989	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.06%

D. How many bed-hold days during this year were paid by Public Aid? 31 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified n/a and days of care provided 0

Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 9/30/2000 Fiscal Year: 9/30/2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	192,568	7,442	5,896	205,906		205,906		205,906			1
2	Food Purchase		179,130		179,130		179,130	(2,334)	176,796			2
3	Housekeeping	39,588	22,329		61,917		61,917		61,917			3
4	Laundry	21,541	3,236	7,548	32,325		32,325		32,325			4
5	Heat and Other Utilities			73,089	73,089		73,089	26	73,115			5
6	Maintenance	53,973	25,067	17,852	96,892		96,892		96,892			6
7	Other (specify):*											7
8	**TOTAL General Services**	307,670	237,204	104,385	649,259		649,259	(2,308)	646,951			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	823,945	50,291	1,406	875,642		875,642		875,642			10
10a	Therapy											10a
11	Activities	56,154	2,306	4,008	62,468		62,468	(95)	62,373			11
12	Social Services	26,037		7,763	33,800		33,800		33,800			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	906,136	52,597	22,777	981,510		981,510	(95)	981,415			16
	C. General Administration											
17	Administrative	95,929			95,929		95,929		95,929			17
18	Directors Fees											18
19	Professional Services			76,821	76,821		76,821	(2,248)	74,573			19
20	Dues, Fees, Subscriptions & Promotions			28,552	28,552		28,552	(596)	27,956			20
21	Clerical & General Office Expenses	63,142	8,973	17,656	89,771		89,771	(7,877)	81,894			21
22	Employee Benefits & Payroll Taxes			215,191	215,191		215,191	(107)	215,084			22
23	Inservice Training & Education			1,867	1,867		1,867		1,867			23
24	Travel and Seminar			12,615	12,615		12,615	1,256	13,871			24
25	Other Admin. Staff Transportation			2,687	2,687		2,687		2,687			25
26	Insurance-Prop.Liab.Malpractice			17,116	17,116		17,116		17,116			26
27	Other (specify):*											27
28	**TOTAL General Administration**	159,071	8,973	372,505	540,549		540,549	(9,572)	530,977			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,372,877	298,774	499,667	2,171,318		2,171,318	(11,975)	2,159,343			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Alpine Fireside Health Center #0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			4,311	4,311		4,311	114,458	118,769			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,968	9,968		9,968	81,456	91,424			32
33	Real Estate Taxes			46,107	46,107		46,107		46,107			33
34	Rent-Facility & Grounds			448,496	448,496		448,496	(448,496)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			508,882	508,882		508,882	(252,582)	256,300			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,392		5,392		5,392		5,392			39
40	Barber and Beauty Shops			12,705	12,705		12,705		12,705			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,588	34,588		34,588		34,588			42
43	Other (specify):* Nonallowable costs			51,703	51,703		51,703	(51,703)				43
44	**TOTAL Special Cost Centers**		5,392	98,996	104,388		104,388	(51,703)	52,685			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,372,877	304,166	1,107,545	2,784,588		2,784,588	(316,260)	2,468,328			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,334)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,340	30		9
10	Interest and Other Investment Income	(879)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,031)	43		24
25	Fund Raising, Advertising and Promotional	(24,156)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(13,384)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,444)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(285,816)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (285,816)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (316,260)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Healthcare, LTD.
Provider # 0018275
9/30/2000

VI. Adjustment Detail, Line 29

Non-Allowable Expenses	Amount	Line
Activity Income Offset	(95)	11
Out-of-Period Legal Fees	(6,193)	19
Uniform Income Offset	(107)	22
Miscellaneous Income Offset	(7,877)	21
Miscellaneous Dues Disallowed	(596)	20
Non-Allowable Taxes	1,484	43
Total	(13,384)	

STATE OF ILLINOIS

Alpine Fireside Health Center

ID# 0018275

Report Period Beginning: 10/1/1999

Ending: 9/30/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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16				16
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Johs Oksnevad	100.00%			Johs Oksnevad	Rockford, IL	Real estate lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Johs Oksnevad	100.00%	$ 26	$ 26	1
2	V	19	Professional fees		Johs Oksnevad	100.00%	3,945	3,945	2
3	V	24	Travel and Seminar		Johs Oksnevad	100.00%	1,256	1,256	3
4	V	30	Depreciation		Johs Oksnevad	100.00%	75,118	75,118	4
5	V	32	Interest		Johs Oksnevad	100.00%	82,335	82,335	5
6	V	34	Rent-Facility & Grounds	448,496	Johs Oksnevad	100.00%		(448,496)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 448,496			$ 162,680	$ * (285,816)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Johs Oksnevad	President	Asst. Adminstr.	100.00%	0	20	50.00	Salary	$ 25,000	L17, C1	1
2	Gordon Oksnevad	Administrator	Administrator	0.00%	0	40+	100.00	Salary	70,929	L17, C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 95,929		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Johs Oksnevad	x		Working Capital	none	09/30/99	169,000	184,240	Demand	0.0600	10,140	6
7	Amcore Bank		x	Improvements and working capital	$9,479.10	05/99	1,000,000	960,423	2013	0.0775	82,335	7
8												8
9	TOTAL Facility Related				$9,479.10		$ 1,169,000	$ 1,144,663			$ 92,475	9
	B. Non-Facility Related*											
10												10
11												11
12									Offset Interest Income		(1,051)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,051)	14
15	TOTALS (line 9+line14)						$ 1,169,000	$ 1,144,663			$ 91,424	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 47,916	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	See below	$ 58,023	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,107	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 36,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 46,107	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	40,303	8
	1996	41,270	9
	1997	43,957	10
	1998	45,628	11
	1999	46,107	12

Accrual Calculation:

1999 Tax bill	46107	1999 bill	46107
% increase	1.05%	1998 paid in 1999	11916
Estimated 2000 taxes	48597 x 9/12=36448 use 36,000		58023

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,000 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	2.8 acres	1961	$ 10,000	1
2					2
3	TOTALS	2.8 acres		$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	127		1973	1973	$ 717,727	$	30	$ 23,924	$ 23,924	$ 710,168	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1973	1,277		10			1,277	9
10				1973	3,172		20			3,172	10
11				1973	694		40	17	17	476	11
12				1973	201		25			201	12
13				1973	93,791		11			93,791	13
14				1973	96,886		34	2,850	2,850	65,122	14
15				1974	8,366		11			8,366	15
16				1975	3,593		10			3,593	16
17				1977	10,055		10			10,055	17
18				1981	2,656		15			2,656	18
19				1982	5,132		11			5,132	19
20				1982	1,063		15			1,063	20
21				1984	21,939		15			21,939	21
22	Smoke detectors			1984	1,145		10			1,145	22
23				1985	3,300		15	110	110	3,300	23
24	Roof			1986	19,094		15	1,273	1,273	18,458	24
25	Kitchen addition & storm sewers			1988	235,818		20	11,791	11,791	147,387	25
26	Kitchen improvements			1989	9,541		20	477	477	5,724	26
27	Black top			1990	5,000		10	488	488	5,000	27
28	Broiler			1991	29,033		20	1,452	1,452	13,794	28
29	Lawn sprinkler			1992	5,000		15	333	333	2,665	29
30	Leasehold improvements			1993	13,972		15	931	931	6,983	30
31	Roof improvements			1994	57,648		15	3,843	3,843	25,158	31
32	Generator			1995	34,924		15	2,328	2,328	12,804	32
33	Air Conditioning System			1999	280,820		15	18,721	18,721	28,082	33
34	Carpeting/Flooring/Wall Covering			1999	81,812		15	5,454	5,454	8,181	34
35	Parking Lot Lights			1999	16,900		15	1,126	1,126	1,689	35
36	TOTAL (lines 4 thru 35)				$ 1,760,559	$		$ 75,118	$ 75,118	$ 1,207,381	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 223,117	$ 2,985	$ 27,345	$ 24,360	3-10 years	$ 210,159	37
38	Current Year Purchases							38
39	Fully Depreciated Assets	303,476					303,476	39
40								40
41	TOTALS	$ 526,593	$ 2,985	$ 27,345	$ 24,360		$ 513,635	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Administrator	1995 Nissan Sentra	1998	$ 6,630	$ 1,326	$ 1,326	$	5	$ 3,315	42
43	Maintenance Truck	1988 GMC Truck	1990	9,700				5	9,700	43
44	Patient Transportation	1998 Chevy Venture M/V	1999	25,654		5,131	5,131	5	7,696	44
45	Patient Transportation	1998 Ford Supreme Bus	1999	49,247		9,849	9,849	5	14,774	45
46	TOTALS			$ 91,231	$ 1,326	$ 16,306	$ 14,980		$ 35,485	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	2,388,383	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	4,311	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	118,769	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	114,458	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	1,756,501	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				5,392		5,392	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 5,392		$ 5,392	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	123,165	123,165	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,466	14,466	6
7	Other Prepaid Expenses	43,510	43,510	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Resident Deposits	212	212	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 181,353	$ 181,353	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,000	13
14	Buildings, at Historical Cost		1,760,559	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	109,159	617,824	16
17	Accumulated Depreciation (book methods)	(102,969)	(1,756,501)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,190	$ 631,882	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 187,543	$ 813,235	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 83,196	$ 83,196	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	184,240	184,240	29
30	Accrued Salaries Payable	45,850	45,850	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,812	24,812	31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,000	36,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,685	1,685	35
	Other Current Liabilities(specify):			
36	Accrued Rent	695,487	695,487	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,071,270	$ 1,071,270	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		960,423	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 960,423	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,071,270	$ 2,031,693	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (883,727)	$ (1,218,458)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 187,543	$ 813,235	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (552,025)	1
2	Restatements (describe):		2
3			3
4	**Prior period adjustment for accrued interest**	(5,102)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (557,127)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(326,600)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (326,600)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (883,727)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,408,327	1
2	Discounts and Allowances for all Levels	(994)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,407,333	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,790	13
14	Non-Patient Meals	2,334	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,047	21
22	Laundry	336	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 26,507	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	879	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 879	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bedhold Income	6,848	28
28a	See attached Schedule 19A	16,421	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,269	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,457,988	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	649,259	31
32	Health Care	981,510	32
33	General Administration	540,549	33
	B. Capital Expense		
34	Ownership	508,882	34
	C. Ancillary Expense		
35	Special Cost Centers	69,800	35
36	Provider Participation Fee	34,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,784,588	40
41	**Income before Income Taxes (line 30 minus line 40)****	(326,600)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (326,600)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
The federal tax return is filed on cash basis.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVII. Income Statement
Line 28A

Revenue	Amount
Activities and Outing Income	95
Vending Machine Income	7,051
Uniform Sales	107
Miscellaneous Income	7,877
Petty Cash Adjustments	1,291
Total	16,421

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 47,434	$ 22.80	1
2	Assistant Director of Nursing	2,119	2,327	42,486	18.26	2
3	Registered Nurses	1,873	1,945	37,957	19.52	3
4	Licensed Practical Nurses	12,986	13,398	230,921	17.24	4
5	Nurse Aides & Orderlies	37,955	39,421	465,147	11.80	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,706	1,786	17,860	10.00	9
10	Activity Assistants	3,776	4,065	38,294	9.42	10
11	Social Service Workers	1,893	1,961	26,037	13.28	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	19,880	9.56	13
14	Head Cook	3,856	3,925	25,655	6.54	14
15	Cook Helpers/Assistants	16,288	17,175	147,033	8.56	15
16	Dishwashers					16
17	Maintenance Workers	3,673	3,870	53,973	13.95	17
18	Housekeepers	4,584	4,754	39,588	8.33	18
19	Laundry	2,140	2,283	21,541	9.44	19
20	Administrator	2,080	2,080	70,929	34.10	20
21	Assistant Administrator	1,040	1,040	25,000	24.04	21
22	Other Administrative					22
23	Office Manager	1,805	1,851	24,762	13.38	23
24	Clerical	2,416	2,679	38,380	14.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,350	108,720	$ 1,372,877 *	$ 12.63	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	151	$ 5,896	L1, C3	35
36	Medical Director	Monthly	9,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,406	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	155	3,882	L11, C3	44
45	Social Service Consultant	155	3,882	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	461	$ 24,666		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Johs Oksnevad	Asst. Adminstr.	100%	$ 25,000
Gordon Oksnevad	Administrator	0.00%	70,929
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,929

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Williams & McCarthy	Legal	$ 4,311
Duane, Morris & Heckscher LLP	Legal	20,273
American Express Tax & Bus Svc.	Accounting	24,746
Altschuler, Melvoin and Glasser LLP	Accounting	14,516
R.E. Harrington	U/C Consulting	300
Care Computer Systems	Computer Services	8,018
Business Management Services	Computer Services	3,587
Entre Computer Center	Computer Services	129
Kronos	Computer Services	244
Acrux	Computer Services	562
Gordon Foods-Software	Computer Services	135
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 76,821

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,295
Unemployment Compensation Insurance	27,008
FICA Taxes	99,068
Employee Health Insurance	42,341
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	1,011
Pre-employment Physicals	11,650
Other Employee Benefits	1,711
TOTAL (agree to Schedule V, line 22, col.8)	$ 215,084

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,560
Health Care Worker Background Check	
(Indicate # of checks performed 136)	1,632
Illinois Health Care Association Dues	5,578
Miscellaneous Dues & Subscriptions	540
Department of Professional Regulations	100
NFIS	400
Miscellaneous Licenses	536
Miscellaneous Publications	610
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,956

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,594
Aide Travel Allowance	2,000
Seminar Expense	9,277
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,871

* Attach copy of IMRF notifications

**See instructions.

C. Professional Services

Allocated from building entity:	
American Express TBS-Accounting	3,945
Out-of-period legal	
Williams & McCarthy	(119)
Duane, Morris & Heckscher	(6,074)
Total	(2,248)

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/1999 Ending: 9/30/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $5,578**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **n/a**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,788** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **34,588**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,334**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **n/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **n/a** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.